Overview of the Medicare Advantage Program
MMA Title II Summary

Title II of the Medicare Modernization Act (MMA) modified and re-named the existing Medicare+Choice (M+C) program established under Part C of title XVIII of the Act. The program is now called the Medicare Advantage (MA) program. Although the MMA made some changes that are already in effect (such as higher payments), several new features will take effect beginning with the 2006 contract year. These new features include authority for new MA regional plans that will be organized as preferred provider organizations (PPOs). The MMA also introduced a new process for determining beneficiary premiums and benefits for 2006 and future years under which MA organizations will submit a "bid" reflecting their revenue needs for covering the benefits they plan to offer. This new process will apply to all MA plans beginning in 2006.

The structure of the final MA regulation is similar to the existing MA regulations, with the exception of Subpart J - which provides special rules for the new regional PPOs; and subparts F and G - which are largely re-written because of the new bidding process. The following summary provides highlights on the final MA regulation.

Subpart A: General Provisions

· Subpart A provides definitions for new types of coordinated care plans established under the Act. Specifically, the final rule provides definitions for specialized MA plans for individuals with special needs ("Special Needs Plans" or "SNPs"), and MA Regional plans. We also define special needs individuals.
· User Fee language is modified to include counseling and beneficiary information on the prescription drug benefit, as well as PDP sponsors' contribution of an applicable portion of the User Fee, based on the Part D drug benefit.

Subpart B: Eligibility, Election and Enrollment

· Subpart B describes the eligibility requirements to elect a Special Needs Plan, and the ability of such plans to restrict enrollment to individuals who are in one or more classes of special needs individuals.
· It also establishes a 1-month grace period (at a minimum) before an MA organization may disenroll a beneficiary for non-payment of the MA plan premium. CMS will provide additional guidance to MA organizations about required beneficiary notification before such an involuntary disenrollment can take effect.
· CMS will continue to have its current "File and Use" program, but has modified the marketing review process for certain materials (as defined by CMS) to include in its "File and Use" Certification program. All MA organizations will be allowed to submit and certify that certain types of materials meet CMS marketing guidelines, if these materials are submitted to CMS at least five days prior to distribution.

Subpart C: Benefits and Beneficiary Protections

- Subpart C highlights that should encourage participation by MA regional plans:
    - Permitting regional PPOs, in certain cases, to partially meet access to care requirements by limiting beneficiary cost sharing to in-network amounts when beneficiaries access routine care from non-network providers and network providers are not readily available;
    - Providing additional fee-for-service payments of up to $25 million a year to "essential hospitals" when treating MA regional plan enrollees;
    - Retaining the existing requirement that non-contracting providers are required to accept as payment in full (when they treat enrollees of non-contracting MA plans) the amount that fee-for-service would have paid.
        - Numerous regulatory reform changes include:
    - Clarifying our policy related to the emergency cost-sharing limit of $50 by explaining that the limit applies only to emergency department services. Once an MA enrollee is hospitalized, normal inpatient hospital cost sharing applies.
    - Eliminating redundant requirements such as removing MA disclosure requirements that are duplicative of activities that CMS already conducts.
    - Eliminating arguably overly-burdensome requirements such as limiting disclosure requirements to the contracting providers (name and addresses) from whom enrollees may reasonably be expected to receive services.

- Subpart C also establishes new beneficiary protections for MA regional plan enrollees such as capping beneficiary cost sharing related to Medicare covered services.

Subpart D: Quality Improvement Program

- Subpart D changes quality activities from quality assurance to quality improvement and deletes for 2006 and future years provisions that enumerated the quality assurance elements that MA plans are required to address for 2005.
- New provisions were added for 2006, including that each MA plan (other than an MA private fee-for-service plan or an MSA plan) must have an ongoing quality improvement program that includes a chronic care improvement program.
- Additionally, MA organizations offering a coordinated care plan must provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. PPO plans offered by an MA organization that does not have an HMO license, however, are only required to collect, analyze, and report data that are furnished by providers that have a contract with the PPO.

Subpart E: Relationship with providers

Subpart E requires that plans provide written assurances that they are in compliance with the physician incentive plan requirements.

Subpart F: Submission of Bids, Premiums and Related Information and Plan Approval

· Subpart F incorporates the legislative provisions related to the new bidding process. In particular, the current Adjusted Community Rate (ACR) process is replaced by a bidding methodology that requires plans to submit bids based on their revenue requirements (costs including profits, where applicable).
· The bids must be actuarially sound, based on original Medicare benefits as one component, supplemental benefits as another, and Part D prescription drug benefits as a third component (if appropriate). The actuarial analysis is partially to ensure that the bids reasonably and accurately represent a plan's expected revenue requirements.

Subpart G: Payment for MA Organizations

· The MMA made improvements to the annual capitation rate methodology:
- o A new capitation rate is created, which is 100% of average fee-for-service Medicare costs (excluding direct medical education and including a VA/DOD adjustment that has been zero to date due to a lack of reliable data). The MMA requires us to rebase the FFS rates no less than every 3 years.
- o The minimum update rate is modified to be the larger of 102% of the previous year's rate, or the prior year's rate increased by the Medicare growth percentage.
- o Beginning in 2005, annual capitation rates will be minimum percentage increase rates except for years when we rebase the FFS rate. In rebasing years, the payment rate is the higher of the minimum percentage increase rate or the FFS rate.
- o Beginning in 2006, we pay the MA organization based on the relationship between each plan's bid for Medicare medical benefits and a "benchmark" amount based on the same capitation rate formula that applies in 2005.
- o For a plan with a bid below its benchmark, we pay the risk-adjusted bid amount plus 75% of the difference between the bid and the benchmark.
- o For a plan with a bid at or above its benchmark, we pay the risk-adjusted benchmark amount.
- o The MMA also specifies an adjustment for variations in county rates within a plan's service area, and an adjustment to make a plan "whole" by ensuring the sum of its risk-adjusted payment amount and beneficiary premium equals its unadjusted bid.

Subpart I: Organizational Compliance with State Law and Preemption by Federal Law

· The Federal preemption of state law was amended under the MMA. Specifically, the MMA provides that MA plan standards preempt state law and regulation with the exception of licensing and solvency requirements.
· State premium taxes are prohibited on any payments CMS makes on behalf of MA enrollees or any premiums that beneficiaries or third parties make to MA organizations for benefits covered under the MA program.

Subpart J: Special Rules for MA Regional Plans

· This new Subpart J incorporates provisions of Sections 1858 of the Act. It reflects unique financial and administrative provisions for MA regional plans and incentives provided to them such as:

- An "essential hospital" network adequacy fund to assist regional plans in forming adequate networks, particularly in rural areas.
- Establishment of regions, for the purpose of maximizing beneficiary access to regional PPO and prescription drug plans.
- Availability of temporary waiver of state licensure.
- A PPO moratorium which precludes an MA organization from offering a new PPO plan in 2006 and 2007 in any area in which it did not already offer a PPO plan in 2005.
- Risk corridors under which risk and savings will be shared for contract years 2006 and 2007 between Medicare and the MA organization offering a regional PPO.
- A Stabilization Fund which can provide additional payment under specified circumstances.

Subpart K: Application Procedures and Contracts for Medicare Advantage Organizations

- In this final rule, in order to make more clear the requirements for MA plans under part 422 and any additional requirements for MA plans offering a prescription drug benefit under part 423, we have added a new amended section §422.500 by revising the section heading to read "Scope and definitions"; designating the undesignated introductory text as paragraph (b) and adding the heading "Definitions"; and adding a new paragraph (a), "Scope," which specifies the scope of the subpart K requirements. This subpart sets forth application requirements for entities seeking a contract as a Medicare organization offering an MA plan**.** MA organizations offering prescription drug plans must, in addition to the requirements of this part, follow the requirements of part 423 of this chapter specifically related to the prescription drug benefit.

- Application Requirements
  - We clarified that a CMS determination that an entity is qualified to act as an MA sponsor is distinct from the bid negotiation that occurs under subpart F of part 422.
  - We clarified that the completion of an application is a condition necessary to contract as an MA organization.
- Evaluation and Determination Procedures
  - The amount of time that an applicant has to remedy an application after receiving an Intent to Deny Notice is 10 days, rather than the 60 days we proposed.
  - We eliminated , as a separate and distinct step in the review process, notification that an application is incomplete.
- General Provisions
  - We have eliminated the mandatory self reporting requirements that we

proposed, but we have added a new requirement that MA-PDs have in place a comprehensive fraud and abuse plan.

- Contract Provisions
    - MA organizations are required to comply with certain Federal laws and regulations. The final regulations reflects our focus on requirements to prevent fraud, waste and abuse and on issues that we are responsible for enforcing, such as the HIPAA administrative simplification rules. This, however, in no way implies that organizations need not comply with other Federal laws and regulations, as applicable.
    - The final rule records that MA organizations retain records for 10 years from the latest contracting period or audit, whichever is latest, to conform to the statute of limitations for the discovery of violations under the False Claims Act.
- Agreements with Federally Qualified Health Centers
    - We have amended paragraph (c) to clarify that financial incentives, such as risk pool payments, bonuses and financial withholds are not considered in determining payments made to FQHCs by CMS.

Subpart L: Effect of Change of Ownership or Leasing of Facilities During the Term of Contract

We changed a reference in the regulations text from "Asset Sale" to "Asset Transfer" in response to comments.

Subpart M: Beneficiary Grievances, Organization Determinations and Appeals

· The MMA did not make any revisions to the statutory requirements in sections 1852(f) and (g) regarding MA grievances and appeals. However, Subpart M of the final rule refines existing grievance and appeal requirements in the following ways:

- We eliminated the requirement for practitioners to provide notices to enrollees at each encounter regarding any decision to deny services. Instead, plans could put these rights in the Evidence of Coverage.
- We eliminated the requirement for a written notice to follow an oral notice of favorable expedited determinations.
- The requirement for physician concurrence for an MA plan to issue a notice of non-coverage is eliminated when an enrollee objects to a discharge. Instead, physician concurrence is required whenever the enrollee's level of care decreases, or the enrollee is discharged.

Subpart N: Medicare Contract Determinations and Appeals

· Reconsideration: Applicability

- We have added an amendment to specify that in the case of a favorable determination, including favorable decisions as a result of a hearing or Administrative review, such determinations be made by July 15 for the contract in question to be effective in January of the following year.

Subpart O: Intermediate Sanctions

- We have clarified that CMS may impose more than one sanction at a time.
- We made editorial changes to clarify the bases and procedures for imposing sanctions**.**